defenceupdate

Quarterly Magazine for MDA National Members

Winter 2013

MDA National
Support Protect Promote

Editor's Note

Many of us read Samuel Shem's classic novel about internship, *The House of God* (1978), as junior doctors or medical students. On page 14, we have a wonderful interview with Dr Stephen Bergman (whose pen name is Samuel Shem).

Dr Bergman is a graduate of Harvard College and Medical School and he was on the faculty of Harvard for 35 years. He wrote *The House of God* while he was undertaking his training in psychiatry. He has authored a number of novels, plays and essays, including *The Spirit of the Place* (2008) which has been described as "the perfect bookend to *The House of God*". The central theme in *The House of God* is connectedness and this continues to guide Dr Bergman's writing and speaking engagements.

On page 3, A/Prof. Julian Rait also touches upon the issues of connectedness and engagement. Julian explores these issues from the perspective of both business and health. The issue of connectedness may also be one of the underlying reasons for the increasing popularity of complementary therapy and Dr Vicki Kotsirilos discusses how to minimise medico-legal risks in complementary medicine on page 6.

Finally, for those Members who have not yet renewed their Membership, on page 5 our Member Services team provides some tips on how to make your renewal easier, including accessing our comprehensive Member Online Services.

Remember that *Defence Update* is now available online. We look forward to your comments and thoughts about the issues and topics covered in our regular Medico-legal Feature and CaseBook series.

Dr Sara Bird
Manager, Medico-legal and Advisory Services

In This Issue

From the President

Engagement in Business and in Health

Emotional engagement with others is a critical factor in creating and sustaining a culture of peak business performance. Indeed, the interpersonal relationships that connect the management and employees of MDA National with our Members (via thoughts and feelings) when managing inquiries, claims or complaints are what Members repeatedly tell me makes our culture distinctive.

Engagement produces better results for all parties involved. The characteristics of high level engagement are attention and personal commitment to our Members' needs. And according to some authors[1], high engagement is based on four primary factors:

- communication and interpersonal dialogue: reciprocal, active involvement and interest
- relationships: care and personal connection with clear results and human impact
- mental resonance: tapping into the power and energy of thoughts and feelings
- motivation: generation of intrinsic and extrinsic rewards to stimulate and maintain energy.

So the team at MDA National understand how to connect with you at stressful times, support your emotional needs in difficult circumstances, and succeed in managing your Membership inquiry, and manage a claim or complaint made against you and/or your practice. Hopefully, our employees also feel emotionally connected to MDA National and its leaders, and are willing to put their knowledge and emotion into action to improve their performance, and that of our organisation, so that we may respond more effectively to your needs.[2]

Equally, a sound risk management strategy for MDA National is to help you understand the most appropriate ways to connect with your patients and educate them about their health.

Most clinicians realise that much of what they do is about connecting with patients and their suffering, with perhaps less than 10% of their treatment involving the science. Especially when time is poor or we are distracted, we get more easily focused on the other 10% of just treating the patient's disease, and ignore the emotional aspects of the doctor-patient relationship.[3]

However, if we are unable to connect with our patients, then it will not matter what treatment we prescribe or what surgery we recommend if things go wrong and/or the treatment doesn't work. Most of us pay little thought to this although many studies have been published which show that the majority of claims and complaints arise in the context of perfectly sound medical care, but where communication issues have been the primary cause.

So while we might go in and out of the consultation room in a matter of minutes with diagnoses made and prescriptions already printed, patients sense this disconnect and can feel as though something is missing from the doctor-patient relationship. And while many patients report feeling particularly vulnerable at certain points of their care, building rapport and establishing trust and confidence in healthcare professionals is particularly important for patients at these stressful times.

Furthermore, the doctors who mentored me repeatedly demonstrated that their calling was not only to teach junior practitioners about the science of medicine, but also that it was a doctor's duty to connect with patients, understand their perspective, and teach them and their families about their condition. Indeed, we can probably identify colleagues who have cared for us or members of our family, and who have displayed the compassion, patience and skill to explain complex problems in clear language, allowing us to make better decisions, and have better control over our lives. And as one of my mentors explained, knowledge is to fear, as oil is to a turbulent sea, bringing calm. And perhaps patients are the greatest benefactors of the deep educational culture of medicine, connecting our senior colleagues who taught us about disease and the patients' experience, with the contemporary bedside connection and the education of our patients.

It might not be a coincidence that the first known use of "doctour," seven centuries ago, was just preceded by a reference in *The South English Legendary*, to "techere", the ancestral root of what would become "teacher" many years later. Or as one oncologist has opined[4] "in a slightly different world, or in a vaguely remembered past, there might have been a time when the office door would open, the nurse step out and she would say, Mrs Smith, the teacher will see you now."

So the humanity of medicine must not be lost in our desire to try the next new drug or pursue a better surgical technique. What we really need to do is to engage, educate and slow down.[3] Medicine has always been rooted in the connection between the doctor and patient, so the more we focus on establishing deep connections with our patients, the more trust and confidence that will be created, and the more satisfied the patient and we will feel.

Like MDA National's partnership with you, it truly can be a win-win!

A/Prof. Julian Rait
MDA National President

For a full list of references, visit defenceupdate.mdanational.com.au /From-The-President.

Notice Board

Our Tasmanian Office is Launched!

Members and friends joined MDA National staff for cocktails and canapés to mark the official opening of the MDA National Tasmanian office on Wednesday 3 April.

Dr Beres Wenck, Vice President of the MDA National Mutual Board, said that the opening of the Tasmanian office represents a significant milestone in our national structure.

The office is located at 206-208 New Town Road, Hobart.

MDA National State Relationship Manager, Jo Edwards with Tony Stevens, CEO, AMA Tasmania.

Dr Beres Wenck, MDA National Vice President and Dr Peter Schlesinger.

Revalidation

Revalidation is defined as the process by which doctors have to regularly show that they are up to date, and fit to practise medicine. This will mean that they are able to keep their license to practise.

The Medical Board of Australia has commenced a consultation process with medical practitioners and the community about revalidation and, as part of this process, the Board convened a forum on 13 March 2013. MDA National was one of the stakeholders who attended the forum, along with representatives from the Colleges, the AMC and the AMA. As part of the forum, the current revalidation systems in the UK, Canada, USA and New Zealand were examined.

MDA National will keep Members informed as the proposals for the revalidation of Australian medical practitioners are developed. We are interested in your comments and views. Please contact us at peaceofmind@mdanational.com.au.

Medico-legal Minefield 2013

With numerous successful Medico-legal Minefield forums already underway, this year's forums have gone off with a bang.

The forums explore communication technologies, particularly telehealth and social media and provide an opportunity to share ideas with peers alongside technological and medico-legal experts.

To book your place in the remaining forums visit mdanational.com.au.

Missed out?

If you were not able to attend a forum, you'll be pleased to know that we will be releasing online educational material relating to this topic later in the year.

Dr Dror Maor, Co-Chair of MDA National's President's Medical Liaison Council with Pip Brown, MDA National Relationship Manager (WA) at Perth City to Surf 2012.

MDA National's **Perth City to Surf Team**

We're taking our *Live Well, Work Well* philosophy to the streets again this year at the Perth City to Surf on Sunday 25 August. Our team will comprise Members and MDA National employees.

Join our team and receive complimentary group training sessions. We'll also keep team motivation levels high with weekly virtual group training pep-emails on fitness, conditioning and nutrition.

Want to join our team or know more?

There is still time to join but hurry, places are limited! Visit perthcitytosurf.com or email us on CityToSurfTeam@mdanational.com.au.

Membership and Policy Renewals Due 30 June 2013

Your renewal invitation is in the post...

When you receive your Renewal Notice, please check the details carefully to ensure it accurately reflects your details and medical indemnity needs.

Don't forget that your Renewal Notice includes your tax invoice/receipt which will become valid upon payment and unless you specifically request one, a receipt will not be sent.

Your Renewal Notice includes your Certificate of Insurance which can be used as proof of indemnity upon payment.

In addition, upon receipt of your payment, we will automatically post you a Certificate of Currency or, if you renew online, you can print your Certificate of Currency immediately after payment.

If you renew through a direct debit arrangement we will post your Certificate of Currency as soon as we've debited your nominated account.

Payment options

We have a variety of payment options to help make renewing by 30 June 2013 quick and easy. See your Renewal Notice for details.

If you've previously set up a direct debit arrangement there's nothing further you need to do to renew. We will simply debit your nominated account with the amount specified on your Renewal Notice on or shortly after 1 July 2013. If you do not wish to continue the direct debit arrangement please contact us immediately on 1800 011 255 or email us at peaceofmind@mdanational.com.au.

Renew online, the easier way!

The easiest way to renew your Membership and Policy is via our Member Online Services (MOS) – it is quick, convenient, secure and all major credit cards are accepted. All you need to do is:

1. **visit mdanational.com.au**
2. **enter your Member Number and Password**
3. **click the "Renew Online" button.**

Forgotten your password? No problem, you can reissue a new password online without having to contact us.

Risk category changes

We have reviewed the breadth and scope of the cover we provide in our risk categories and are pleased to advise you of the following changes that may be applicable to your practice:

- Increased private billings of up to $10,000 from non-procedural practice for Members in the Employer Indemnified category.
- A review of procedures covered under the General Practice categories.
- Re-categorisation of some of our Physician Categories to Level 1A.
- A new Student category for our student Members.
- A new Final Year Student/Intern category that provides up to 24 months of continuous cover, providing a seamless transition from being a medical student to a new graduate in the first 18 months after graduation.
- Unlimited private billings for our Post Graduate and Doctors in Specialist Training (DIST) categories.

Please refer to the Risk Category Guide for further details regarding these changes.

Policy changes

We've enhanced your coverage under your Professional Indemnity Insurance Policy for 2013/14, as outlined in your Renewal Notice. Please review these in conjunction with the Professional Indemnity Insurance Policy Combined Financial Service Guide, Product Disclosure Statement and Policy Wording V.10 included in your renewal pack.

You can download this document at mdanational.com.au or contact our Member Services team on 1800 011 255.

Thank you for your Membership. We look forward to continuing to support and protect you.

Tonya Timpano
Manager, Member Services

Complementary Medicine: Minimising Medico-legal Risks

Dr Vicki Kotsirilos outlines tips and strategies to avoid medico-legal risks in complementary medicine.

Reflecting the international experience, surveys of Australian GPs demonstrate that many doctors are integrating various complementary medicines and therapies into clinical practice to help improve quality of care and provide treatment options for patients. The National Prescribing Service conducted a nationwide survey of Australian GPs in 2008 and found that about 30% of GPs described themselves as practising "integrative medicine" (IM) defined as "a holistic approach to health care that integrates conventional medical care with complementary therapies".[1] Complementary medicines (CMs) or therapies include counselling, meditation, relaxation therapies, hypnosis, acupuncture, nutritional medicine, herbal medicine, environmental medicine, physical and manipulative medicine. Many doctors are finding the flexibility of having such skills and knowledge at their disposal most useful, especially when conventional approaches are meeting with patient disapproval or are producing unwanted side-effects. It is estimated that about 70% of the community are using some form of complementary medicine.[2] Medical practitioners have a responsibility to be aware of these therapies, to consider people's attitudes and beliefs, and be aware of potential harm to the patient, including herb-drug interactions.

Adverse reporting for CMs

There are many reasons why patients are turning to CMs, including a philosophical desire for a more "natural approach" to treating their disease, a fear of, or having experienced adverse reactions and side-effects to medication or surgery. While adverse reporting of side-effects for CMs to the Therapeutic Goods Administration are extremely low (less than 2%) compared with pharmaceutical medicines (of about 98%)[3], there are still many risks doctors should be aware of when they decide to use CMs or refer to other complementary health practitioners.

Scientific evidence for CMs

There is now a growing body of scientific evidence to support some CMs, such as some herbal medicines, acupuncture, nutritional medicine, and stress management techniques. Most of these studies can be accessed from Cochrane reviews and Pubmed. However, many alternative practices such as reflexology, kinesiology, aromatherapy and homeopathy to date have very little or no scientific evidence.

The use of CMs should have certain boundaries. Their use should not be to the exclusion of a clearly indicated, safe, effective and superior orthodox therapy. A recent Coronial Inquest into the death of Penelope Dingle[4] highlighted this issue. In making choices, patients need to be well-informed about the range of reasonable options for both orthodox and complementary therapies. Based on clear information patients should then be allowed to make their choices as to what treatment they wish to pursue. It is easier to recommend CMs when they have evidence for safety and efficacy. Follow-up of patients to monitor their treatment response needs to be under the care of their primary medical practitioner.

Medicare and Professional Services Review Scheme

Doctors who practice IM often spend more time with patients and use longer consultation item numbers such as Level C and D.

The Health Insurance Act 1973 (Cth) defines inappropriate practice as a "conduct in connection with rendering or initiating services that would be unacceptable to the general body of members of that profession".

When billing for Level C or D ensure you can confidently reply in the positive to the following two questions:

1. Does the service rendered comply with the time and content requirements of the MBS item descriptor?
2. Would the majority of my peers accept that the treatment provided during the service is clinically appropriate for this patient?

Avoid using Level C and D item numbers based on time alone, without regard to the content requirements of the MBS item descriptors. Stay clear of using unreasonably high patterns of pathology ordering for every patient as a sole route to a diagnosis, with little regard to the history and examination.

Supply of preparations to patients

Doctors should not have a financial interest in the sale of any preparation to a patient and, if necessary, charge only a small price over and above the wholesale price to cover any administrative or other costs of supplying the product.[5]

Dr Vicki Kotsirilos is a GP, Chair of the RACGP IM network and co-author of *A Guide to Evidence-based Integrative and Complementary Medicine*.

Medico-legal tips to avoid problems:

1. If you practice as a qualified medical practitioner you cannot put aside that qualification. Be familiar and guided by *Good Medical Practice: A Code of Conduct for Doctors in Australia*.
2. Be clear which treatments are supported by scientific evidence and which are not. Be prepared to provide this evidence to patients and colleagues when requested. There are many CMs that may not be backed by evidence but have been in effective use for hundreds of years or been shown to be useful in clinical experience.
3. Do no harm. Consider using CMs if they are as safe as conventional therapies.
4. There are some CMs that pose high risk such as injectable therapies. Where therapies are of high risk, they should be matched with greater scientific evidence to justify their use.
5. Critically appraise your clinical practice. Are you really making a difference? Could simpler, less expensive approaches such as lifestyle changes help the patient attain the same clinical benefits?
6. Advise patients on what orthodox treatments are available to help them make informed choices of all therapies. It is important not to deny patients an orthodox approach and run the risk of delaying effective treatment.
7. Clearly document in your medical notes what choices the patient has made about their treatment, why they refused orthodox mainstream care. This is called "informed refusal" and is just as important as "informed consent".
8. Informed consent – allow patients to make informed choices at all stages of their assessment, investigation and treatment.
9. Inform patients of risks and benefits of any proposed CMs they choose to trial and document these clearly in your clinical notes. Consider asking patients to sign a consent form in which they acknowledge that you have fully advised them of both conventional and alternative treatment options, benefits/risks associated with their use and the costs associated with the treatment.
10. Ensure medical records comply with regulatory standards. Your notes should be easily readable by any medical practitioner and use the language of the doctor. Avoid using alternative language. Remember you are a doctor first!
11. Ensure your clinical notes include extensive relevant history, physical examination, diagnosis, differential diagnosis, relevant investigations, a management plan and follow-up to monitor progress. Document potential risks and side-effects.
12. Only refer to reputable registered qualified health practitioners.
13. Follow up patients to assess their response to treatment and monitor for adverse reactions to treatment.
14. Avoid routine ordering sets of tests. Be patient specific and ensure tests are clinically relevant to the presenting problem.
15. Ensure your clinical practice is guided by current knowledge and skills in your area of practice.
16. Be honest in relation to financial and commercial matters.
17. Act honestly and only in your patient's best interests – even if you are not knowledgeable in the latest research, doctors should be honest in saying "I cannot advise you as I don't have enough knowledge or experience in this area to comment" – rather than dismissing a therapy if you are not sure of the evidence.

1 Brown J, Morgan T, Adams J et al. *Complementary Medicines Information Use and Needs of Health Professionals: General Practitioners and Pharmacists*. National Prescribing Service, December 2008. Available at: nps.org.au/__data/assets/pdf_file/0020/66620/CMs_Report_-_HP_-_Apr_09.pdf.

2 Xue CC, Zhang AL, Lin V et al. *Complementary and alternative medicine use in Australia: a national population-based survey*. J Altern Complement Med 2007; 13(6): 643-650.

3 Statistics provided by the Office of Medicines Safety Monitoring at the Therapeutic Goods Administration. 25 March 2009.

4 Inquest into the death of Penelope Dingle (nee Brown). Available at: safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Dingle_Finding.pdf.

5 *Good Medical Practice: A Code of Conduct for Doctors in Australia*. Sections 8.11 and 8.12. Available at: medicalboard.gov.au/Codes-and-Guidelines.aspx.

Pecuniary Interest
Duty of Disclosure

In the modern world of commerce and medicine it is not unusual for medical practitioners to hold a financial interest in companies that manufacture medical products, prostheses or which provide diagnostic services or private facilities at which their patients may be treated.

In our experience, there is at times a misconception that medical practitioners are prohibited from using products from companies in which they have a financial interest, or in relation to which they have made a referral or recommendation. *The Health Practitioner Regulation National Law Act 2009* (the National Law) does not prohibit the use of products from companies or referrals to companies in which a medical practitioner has a pecuniary interest. However, it does establish strict criteria for ensuring that all pecuniary interests are disclosed. Indeed, the National Law provides that a failure to disclose a pecuniary interest in giving a referral or recommendation is unsatisfactory professional conduct, which could lead to disciplinary action.

What is a pecuniary interest?

For the purposes of the National Law a "pecuniary interest" includes a medical practitioner who holds 5% or more of the issued share capital of a public company or has any interest in a private company. Such an interest would include a financial interest in a private hospital or day surgery facility.

Duty of disclosure

To ensure compliance with the National Law, medical practitioners are required to disclose their pecuniary interest to their patients prior to treating them, and to hospitals where they may operate and use products from the company in which they hold the interest.

Similarly, there are various professional Codes of Conduct which specifically touch upon conflicts of interest and a medical practitioner's obligation to appropriately disclose a pecuniary or commercial interest.

Paragraph 8.11 of the Medical Board of Australia's *Good Medical Practice: A Code of Conduct for Doctors in Australia*[1] states that:

A conflict of interest in medical practice arises when a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient…good medical practice [is]…recognising potential conflicts of interest in relation to medical devices and appropriately managing any conflict that arises in your practice…[and] not allowing any financial or commercial interest in a hospital, other health care organisation or company providing health care services or products to adversely affect the way in which you treat patients. When you or your immediate family have such an interest and that interest could be perceived to influence the care you provide, you must inform your patient.

Paragraph 8.12 deals specifically with financial and commercial dealings and provides that a practitioner must be:

… transparent in financial and commercial matters including…declaring to your patients your professional and financial interest in any product you might endorse or sell from your practice, and not making an unjustifiable profit from the sale or endorsement.

Professional associations or craft groups may also have a Code of Conduct which deals with pecuniary interests and/or conflict of interest and practitioners should be aware of Codes of Conduct for their particular specialty or craft group. For example, clause 2 of the Australian Orthopaedic Association Position Statement on Interaction with Medical Industry (2009) [2] states that:

… a member must disclose to colleagues, institutions, and other affected entities, any financial interest in a medical device… if the member or institution with which they are associated, has received or will receive any direct or indirect payment or a financial or other benefit from the inventor or manufacturer of the medical device…

Compliance with obligation of disclosure

Medical practitioners should ensure appropriate measures are in place to disclose any pecuniary interest to all patients, as well as to all hospitals where the medical practitioner may operate or provide clinical services.

In relation to patients, a medical practitioner should ensure that the disclosure of the pecuniary interest is part of the provision of informed consent. This can take the form of a direct discussion with the patient, but it is also recommended that the medical practitioner make disclosure of the pecuniary interest on relevant consent forms and/or by display of a notice in the practitioner's rooms. Disclosure of a pecuniary interest on the medical practitioner's website would, where relevant, also be recommended.

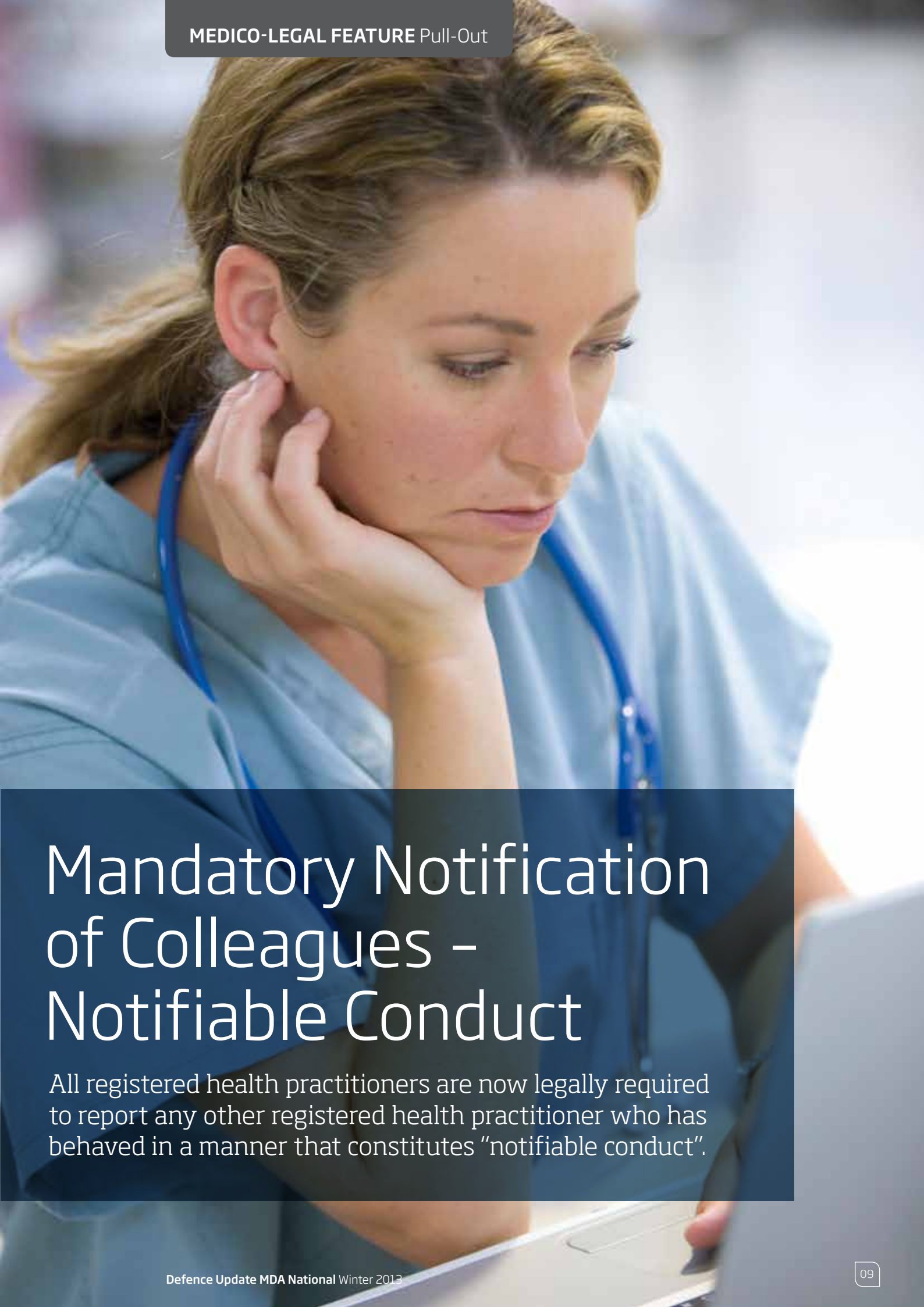
Scott Chapman, Partner, TressCox Lawyers.

1 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

2 Australian Orthopaedic Association *Position Statement on Interaction with Medical Industry.* Available at: aoa.org.au/Resources/Standards_and_policies.aspx.

What do you think?

Share your comments with us at *Defence Update* online **defenceupdate.mdanational.com.au/pecuniary interest**



Mandatory Notification of Colleagues – Notifiable Conduct

All registered health practitioners are now legally required to report any other registered health practitioner who has behaved in a manner that constitutes "notifiable conduct".

Mandatory Notification of Colleagues – Notifiable Conduct

The National Registration and Accreditation Scheme for health practitioners (the Scheme) was introduced on 1 July 2010. As part of the Scheme, all registered health practitioners are now legally required to report any other registered health practitioner who has behaved in a manner that constitutes "notifiable conduct".

Making a mandatory notification is a serious step to prevent the public from being placed at risk of harm and should only be taken on sufficient grounds.

What is "notifiable conduct"?

Notifiable conduct is defined in the *Health Practitioner Regulation National Law Act 2009* (the National Law) and means the practitioner has:

- **practised the practitioner's profession while intoxicated by alcohol or drugs; or**
- **engaged in sexual misconduct in connection with the practice of the practitioner's profession; or**
- **placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or**
- **placed the public at risk of harm because the practitioner has practised the profession in a way that constitutes a significant departure from accepted professional standards.**

"Impairment" is defined in the National Law as a person who has "a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect the person's capacity to practice the profession". It should be noted that the practitioner's impairment must place the public at risk of substantial harm for the threshold for mandatory notification to be met.

Who is required to report "notifiable conduct"?

The Scheme imposes a duty on all registered health practitioners and employers to report notifiable conduct. This means that there is a legal obligation to report a registered health practitioner who the notifier, in the course of practising their profession, has formed a "reasonable belief" (see opposite) that the practitioner has behaved in a way that constitutes notifiable conduct.

The 14 health professions which are currently covered by the Scheme are:

- Aboriginal and Torres Strait Islander health practitioners
- Chinese medicine practitioners
- chiropractors
- dental care practitioners
- medical practitioners
- medical radiation therapists
- nurses and midwives
- occupational therapists
- optometrists
- osteopaths
- pharmacists
- physiotherapists
- podiatrists
- psychologists.

The obligation to make a mandatory notification applies to the conduct or impairment of all registered practitioners, and not just those in the same health profession as the practitioner who is making the notification.

Education providers also have an obligation to make a mandatory notification in relation to students, if the provider reasonably believes a student who is enrolled with the provider, or who is undertaking clinical training with the provider, has an impairment that in the course of the student undertaking clinical training, may place the public at substantial risk of harm.

Are there any exceptions to the requirement to make a mandatory notification?

There are particular exceptions which relate to the circumstances in which the practitioner forms the reasonable belief about notifiable conduct. Exceptions to the requirement of practitioners to make a mandatory notification include where the practitioner:

- Is employed or otherwise engaged by a professional indemnity insurer. That is, medical practitioners who are employed or engaged by MDA National are exempted from the obligation to make a mandatory notification.
- Is exercising functions as a member of a quality assurance committee, council or other body which prohibits the disclosure of the information.
- Reasonably believes that someone else has already made a notification.

Also, in Western Australia only, practitioners are exempted from the reporting requirements in the course of providing health services to other health practitioners or students.

What is "reasonable belief"?

The threshold to trigger the requirement to report notifiable conduct in relation to a practitioner is high, and the practitioner or employer must have first formed a "reasonable belief" that the behaviour constitutes notifiable conduct. For practitioners reporting notifiable conduct, a reasonable belief must be formed in the course of practising the profession.

A reasonable belief requires a stronger level of knowledge than mere suspicion. Generally it would involve direct knowledge or observation of the behaviour which gave rise to the notification. Mere speculation, rumours, gossip or innuendo are not enough to form a reasonable belief.

However, conclusive proof is not needed. A report should be based on personal knowledge of facts or circumstances that are reasonably trustworthy and that would justify a person of average caution, acting in good faith, to believe that notifiable conduct has occurred or that a notifiable impairment exists.

How do I make a notification?

The National Law provides for notifications to be made to the Australian Health Practitioner Regulation Agency (AHPRA), which receives notifications and refers them to the relevant Board. The notification should be made as soon as practicable and include the basis and the reasons for the notification; that is, practitioners, employers and education providers must say what the notification is about.

Practitioners should document the reasons for the notification including the date and time that they noticed the conduct or impairment.

Am I protected if I make a notification?

The National Law protects practitioners, employers and education providers who make notifications in good faith (well-intentioned or without malice). Protection is provided from civil, criminal and administrative liability, including defamation, for practitioners making notifications in good faith.

Making a notification is not a breach of professional etiquette or ethics, or a departure from accepted standards of professional conduct.

The National Law also provides for voluntary notifications for behaviour that presents a risk but does not meet the threshold for notifiable conduct, and similar protections apply for voluntary notifications.

What if I fail to make a notification?

There are no penalties prescribed under the National Law for a practitioner who fails to make a mandatory notification; however, a practitioner who fails to make a mandatory notification when required to do so may be subject to disciplinary action by their registration Board.

There are consequences for an employer who fails to notify AHPRA of notifiable conduct. If AHPRA becomes aware of such a failure, they must give a written report about the failure to the responsible Minister for the participating jurisdiction in which the notifiable conduct occurred. The Minister must report the employer's failure to notify to a health complaints entity, the employer's licensing authority or another appropriate entity in that participating jurisdiction.

Current experience with mandatory reporting

In 2010 – 2011 AHPRA received 428 mandatory notifications relating to registered health practitioners, representing 8% of the total notifications.[1] Nurses comprised 58% and medical practitioners comprised 34% of these mandatory notifications. Pharmacists, psychologists, physiotherapists, midwives and dentists were the subject of a smaller number of notifications and there were no mandatory notifications in relation to chiropractors, optometrists, osteopaths and podiatrists.

Medical practitioners had the highest rate of mandatory notifications, at 16 per 10,000 medical practitioners. In comparison, there were seven per 10,000 nursing mandatory notifications and six per 10,000 mandatory notifications related to pharmacists.

Approximately 60% of the notifications were made by employers and 40% by other health professionals. There was considerable variation in the rate of mandatory notifications across the states and territories. Mandatory notification rates were highest in South Australia with 27 notifications per 10,000 practitioners, compared with a national rate of eight per 10,000 practitioners.

The basis for nearly 60% of the mandatory notifications was that the practitioner was placing the public at risk of harm due to practice that constituted a significant departure from accepted professional standards. Impairment accounted for nearly 30% of notifications, sexual misconduct comprised approximately 7% of notifications and intoxication was involved in 4% of cases.

Of the mandatory notifications assessed during 2010-2011, 57.7% were referred for investigation. In 6% of cases immediate action was taken. The relevant Board took no further action in 16.8% of cases.

In 2011-2012, the overall number of mandatory notifications increased by about 40% compared to 2010 – 2012.[2] Nurses accounted for 54% of notifications and medical practitioners for 28%.

South Australia continued to have the highest rate of mandatory notifications, while Victoria had the lowest rate.

The medical profession had the highest notification rate at 22.3 per 10,000 practitioners on a national basis.

The source of mandatory notifications about registered practitioners was evenly divided between employers (49%) and practitioners (51%).

The reason for the mandatory notifications involving medical practitioners was:

- 89/149 placed the public at risk of harm due to practice that constituted a significant departure from accepted professional standards
- 35/149 impairment that placed the public at risk of substantial harm
- 9/149 practised under the influence of drugs or alcohol
- 8/149 sexual misconduct in connection with practice (Note: 8 cases were not classified).

In about 60% of the mandatory notification cases closed in 2011-2012, the relevant Board determined that no further action was required.

Further reading

Medical Board of Australia. *Guidelines for mandatory notifications*. Available at: **medicalboard.gov.au/Codes-Guidelines-Policies.aspx**.

1 The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme, *Annual Report 2010-11*. Available at: ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx.

2 The Australian Health Practitioner Regulation Agency and the National Boards, reporting on the National Registration and Accreditation Scheme, *Annual Report 2011-12*. Available at: ahpra.gov.au/Legislation-and-Publications/AHPRA-Publications.aspx.

Mandatory Reporting A Medico-legal Adviser's Perspective

More than two years after the introduction of the National Law, it is appropriate to reflect on MDA National's experience with the mandatory reporting of colleagues.

It is my view that the legislation has introduced a number of unintended and detrimental consequences for medical practitioners and their patients, and the public interest benefits of improved patient safety which underpin the rationale for the legislation are not being achieved.

Problems with mandatory reporting

The main concern about the mandatory reporting legislation is that it is putting patients at risk of harm. These concerns arise primarily out of the "impairment" and "standard of care" provisions of notifiable conduct.

It is apparent that medical practitioners who are physically or mentally unwell may fail to seek their own treatment for fear that in doing so they may be reported, and ultimately lose their professional livelihood. These concerns may result in a delay in a practitioner seeking necessary medical care, thus increasing the risk to themselves and the patients they serve. The effect is that a profession that is devoted to the medical care of their patients, putting their patients first, is not afforded the same care when they wear the mantle of a patient. Simply exhorting doctors not to be fearful of the law will not remove this perception.

Mandatory reporting may also discourage practitioners from disclosing incidents and seeking advice from colleagues, both of which are vital to maintaining professional competence and improving performance. The willingness of health practitioners to openly discuss medical errors is a vital foundation of any efforts to identify adverse events and introduce processes to avoid them. The creation of this open, trusting and learning environment will benefit patients, and is placed at risk by the legislation.

It is instructive to examine the potential barriers to dealing with poorly performing colleagues. Will the introduction of mandatory reporting remove or reduce these barriers? A survey of American medical practitioners found that when confronted by an incompetent colleague, 55% to 67% of the practitioners actually reported the colleague to the relevant regulator.[1] What then were the reasons given for not reporting to the regulator in this situation? The most frequently cited reason for those practitioners who did not report was that someone else had taken care of the problem (19%), followed by the belief that nothing would happen as a result of the report (15%) and fear of retribution (12%). In considering these reasons, it is entirely reasonable not to report when others had already taken action and, indeed, one of the exemptions to mandatory reporting is knowledge that someone else has already reported the colleague.

The study also revealed that medical practitioners were well aware of their ethical and professional obligations with respect to managing poorly performing or impaired colleagues.

Where to from here?

What changes to the National Law can be made to achieve an appropriate balance between the rights of individual medical practitioners and the right of the public to receive safe and competent medical care?

The exemption currently enjoyed by treating doctors in Western Australia should be introduced across Australia to minimise the perception (and, at times, the reality) that medical practitioners should be fearful of seeking their own health care. Importantly, this change will bring consistency and make it a genuine National Law.

The legislative protections for health practitioners making a notification about a colleague to AHPRA should be preserved and strengthened, if needed. Practitioners should be reminded when making a notification that it can be done anonymously. This may assist the small proportion of practitioners who fear retribution from a colleague if they make a notification.

The wording of the "notifiable conduct" provisions in the National Law should be amended to reflect the intended focus of the legislation on the protection of patients prospectively, rather than examining past conduct; that is, the wording should be changed to "practising" rather than "practised", and "placing" instead of "placed the public at risk".

These legislative changes should be made to ensure that patients who are cared for by the medical profession, including other health practitioners, receive safe and competent medical care.

Dr Sara Bird, Manager, Medico-legal and Advisory Services, MDA National.

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1 DesRoches CM, Rao SR, Fromson JA. *Physicians' Perceptions, Preparedness for Reporting, and Experiences Related to Impaired and Incompetent Colleagues.* JAMA 2010;304(2):187-193.

Supporting Doctors' Mental Health with *beyondblue*

Barriers to medical practitioners and students seeking help for depression include concerns about the stigma in the profession, embarrassment, possible impact on career development and worries about being allowed to continue to practice medicine.[1]

Studies have also shown that doctors involved in a medico-legal matter have a higher prevalence of anxiety and psychiatric morbidity.[2]

That is why, as part of our Corporate Social Responsibility (CSR) Program, MDA National has joined forces with the Australian charity – *beyondblue* to promote mental health awareness throughout the medical community. In particular we are supporting *beyondblue's* world first National Mental Health Survey of Doctors and Medical Students.

MDA National President, A/Prof. Julian Rait, said the association with *beyondblue* fosters the natural synergy between both organisations and helps to achieve the common goal of supporting doctors to provide the best possible care in the community.

"Our rationale is threefold – to support doctors' mental health; to ensure doctors are supported in caring for patients with mental health issues; and to promote understanding and compassion within the medical community, starting with our own organisation. As a doctors for doctors mutual, MDA National has been supporting, protecting and promoting medical practitioners since 1925 so doctors' health and wellbeing has always been a significant part of that support.

This year, by working with *beyondblue*, we aim to deepen that support by promoting awareness and reinforcing the important information and leading research that *beyondblue* has developed on mental health for doctors, medical students and the Australian community."

beyondblue's National Mental Health Survey

beyondblue's National Mental Health Survey of Doctors and Medical Students will:

- help the medical sector better understand the issues associated with mental health in the sector
- assist in the development and delivery of mental health services and support for doctors and medical students.

Results of the survey will be available in late July and be covered in the Summer issue of *Defence Update*.

Mental health resources for medical practitioners

beyondblue beyondblue.org.au (1300 224 636)

A national organisation that provides information about depression to consumers, carers and health professionals.

Doctors' Health Advisory Service (DHAS)
doctorshealth.org.au

A 24 hour confidential professional helpline for medical practitioners and their families.

ACT (0407 265 414)
NT (02 9437 6552)
NSW (02 9437 6552)
QLD (07 3833 4352)
SA (08 8366 0250)
TAS AMA Peer Support Service (1300 853 338)
VIC (03 9495 6011)
WA (08 9321 3098)

MDA National's Doctors for Doctors Personal Support Program (1800 011 255)

Peer support program for Members during the course of a complaint, investigation or other process, from a doctor who has experience in the medico-legal process.

1 *beyondblue*'s systematic literature review, August 2010.

2 Nash L, Daly M, Johnson M at al. *Psychological morbidity in Australian doctors who have and have not experienced a medico-legal matter: cross sectional survey.* Aust N Z J Psychiatry 2007; 41:917–925.

We Pay a Visit to *The House of God* – And You Are All Invited!

If you have ever BUFFED and TURFED a GOMER, it is highly likely you have read – or trained under someone who has read – Samuel Shem's seminal work of medical fiction, *The House of God*.

Dr Jane Deacon and I had the great pleasure of meeting award winning author Dr Stephen Bergman and his wife Janet Surrey, at the Pre-Vocational Medical Education Forum held in Perth in November 2012.

The House of God

Despite the book being written in the mid-seventies, at a time of far less technology and far more shenanigans in the on-call room, the central theme of connectedness still holds true today and continues to guide Dr Bergman's writing and public speaking commitments.

Being a junior doctor is tough and this book simply says "it's okay – you are not alone."

When Dr Bergman wrote *The House of God*, over a period of three years during his training as a psychiatry registrar, little did he know that his cathartic tome would be read and loved by a third generation of medical practitioners worldwide.

Dr Bergman was just starting his psychiatry practice when the book was published in 1978, and due to concerns about the effect his "sexy and radical book" might have on his patients, the penname Samuel Shem came into being. With the publicity surrounding the release of the book, patients soon discovered their therapist was the author but Dr Bergman says their interest only lasted about 30 seconds before their own problems again became far more important than the celebrity of their therapist.

More than fiction

If you have read *The House of God*, it may come as a surprise that one of the most important characters in the book is entirely fictional. The Fat Man was, according to the author, the doctor the interns *needed* as opposed to the doctors they actually got.

Dr Bergman remains good friends with many of the doctors who joined him in his intern year and upon which his (mostly) beloved characters were based. His former colleagues were immensely proud to be part of the book, so much so that Dr Bergman says there are significantly more doctors in America who claim to have been "in the book" than those who actually were!

The book contains a lot of sex, and I asked Dr Bergman if this was a sign of the times, or a way to share the trauma of internship?

Dr Jane Deacon, Dr Stephen Bergman and Ms Nerissa Ferrie.

When I wrote the book it was a totally different time. I did my internship in 1973/1974. It was pre-AIDS so pretty much any disease you got could be cured, and it was a very sexual atmosphere. As described in the book, a lot of sex was happening.

Dr Bergman instinctively knew that without the light relief of sex and black humour, *The House of God* would be a pretty grim read.

After *The House of God* was published in 1978, Dr Bergman focused on the practice of medicine and avoided the publicity trail, despite the popularity of the book and the intense interest it generated. But something changed. A letter from an intern led Dr Bergman to realise that the book had become far more than a work of fiction.

The letter read *I'm on call tonight in a veterans' hospital in Tulsa, Oklahoma and if it weren't for your book, I'd kill myself.*

Nerissa Ferrie, MDA National Medico-legal Advisor.

More?

To read about the Laws of the House of God and Dr Bergman and Janet's lifelong commitment to "staying human" through their play Bill W and Dr Bob, visit **defenceupdate.mdantional.com.au/house-of-god.**

CaseBook

Treating Staff Members

MDA National Medico-legal Adviser, Dr Jane Deacon discusses problems associated with treating staff members.

Case history

Dr Geep was approached by one of his receptionists. She told Dr Geep that she had been suffering from back pain for a while and she would like him to give her a referral for a CT scan of her back, which she thought would just give her "peace of mind". She said that as he was fully booked today she didn't need a consultation, if he could just give her the referral.

How should doctors respond to such requests? Is it good practice to provide medical care to your staff?

Medico-legal issues

Medical centre staff may feel that easy access to free medical care is an unwritten perk of the job. Many staff also develop great confidence in the doctors with whom they work and they may want to become their patients.

This request for a "corridor consultation", where the staff member has not provided a full history and there has not been an opportunity for a physical examination may result in poor or fragmented care, inadequate documentation and lack of follow up.

To ensure appropriate medical care, the doctor requires access to information of a sensitive nature. In the setting of a formal consultation, the doctor would have access to this information. The doctor may learn about sensitive issues that are awkward for the doctor as an employer because they may affect the workplace.

Confidentiality issues may arise from this. For instance, when treating a staff member, the doctor may not document sensitive information because other staff may have access to the information. The staff member may not disclose that information in the first instance because of confidentiality concerns.

There is potential for conflict when making medical judgements about the severity of an ailment. It may be difficult to be objective if sending someone home sick is going to be a hardship for the practice. Treating staff members for a work related injury is also a potential minefield.

The Medical Board of Australia recommends that doctors "...avoid providing medical care to anyone with whom you have a close personal relationship". Treating staff members is inappropriate due to the "...lack of objectivity, possible discontinuity of care, and risks to the doctor and patient".[1]

The American College of Physicians also recommends treating staff only in an emergency and to transfer such patients to another doctor as soon as possible.[2]

Requests made by staff or colleagues may be difficult to refuse due to social pressures in the workplace. Refusing to treat staff may also affect the working relationship by introducing tensions. Workplaces should have a formal policy about staff treating staff except in emergencies. It is preferable to make this a practice policy that staff are aware of at the outset.

Summary Points

- Treating staff members should be approached cautiously as there is potential for less than adequate care.
- Workplaces should consider having a formal policy about treatment of staff that all staff members are aware of.

If you have further questions or require specific advice, contact our Medico-legal Advisory Service on 1800 011 255 or email advice@mdanational.com.au.

1 *Good Medical Practice: A Code of Conduct for Doctors in Australia.* Available at: medicalboard.gov.au/Codes-Guidelines-Policies.aspx.

2 Snyder L. American College of Physicians Ethics Manual. *Ann Intern Med* 2012;156:73-104.

CaseBook

Misuse of Opioid Drugs

MDA National Claims Manager, Alice Cran, outlines the challenges of prescribing opioids.

Case history

Dr P received a letter from the Health Department requesting an interview in relation to six patients. Dr P had been prescribing oxycodone to these patients over a prolonged period without a permit.

Discussion

The misuse of prescription drugs, particularly opioid analgesics and sleeping tablets, is emerging as a serious public health issue. In 2008, there were 551 accidental overdoses due to opioids in Australia, of which 70% were thought to be due to pharmaceutical opioids.[1] Research has also shown a 152% increase in oxycodone prescriptions from 2002-2008.[2] Recently, attention has been drawn to the alarming levels of misuse of benzodiazepines. While not currently classified as Schedule 8 drugs[3], benzodiazepines (and in particular, alprazolam) are being associated with serious health risks and crimes, and have been detected in heroin-related deaths over the past 21 years[4]. While opioid analgesics play a legitimate role in the management of pain[5], the increased availability of opioid analgesics has seen an associated increase in the non-medical use and diversion of these drugs to persons other than the person for whom the drug was initially prescribed[3]. Further, prescription opioid analgesics have significant "street value" and may be sold on the black market for illicit recreational use or may be traded for other drugs. For instance, a concessional prescription for 50 alprazolam tablets purchased under the Pharmaceutical Benefits Scheme (PBS) can yield a potential street value between $150 to $250.[4]

Throughout Australia, the prescription of opioid analgesics (categorised in health legislation as Schedule 8 drugs or "S8s") is closely regulated because of the drugs' addictive potential and prevalence in misuse and trafficking. Before prescribing an S8 drug, a medical practitioner must take all reasonable steps to ensure that a therapeutic need exists. Once a therapeutic need is established, medical practitioners are required to comply with state-specific health legislation and, where necessary, obtain an authority (or permit). These authorities are distinct from, and in addition to, any authority under the PBS for scripts.

In general, the regulatory regime that applies to the prescription of S8 drugs distinguishes between the treatment of drug dependent and non-drug dependent persons. In the context of prescription drugs, a drug dependent person is defined as someone who consumes prescribed drugs in a manner that presents a risk to that person's health; or, as a result of the repeated consumption of a prescription drug, acquires an overpowering desire for the continued consumption of that drug and is likely to suffer mental or physical distress upon ceasing the drug.[5] Characteristics of a drug dependent person include having a history of substance misuse and being identified as a "doctor shopper". Tactics typically used by drug dependent persons in support of their request for particular treatment include:

- Claiming to have recently moved from the country or interstate and needing to continue receiving treatment.
- Feigning pain and requesting a particular drug by name, by description or by exclusion of other drugs.
- Claiming to have either lost a prescription of tablets or been a victim of theft (police reports are often produced as "proof" of the theft).
- Presenting with a convincing description of their symptoms, from exhibiting old scars or other signs of injury or physical defect to the production of a report and/or x-ray from a hospital or another doctor.[6]

In all states and territories, it is a mandatory requirement for medical practitioners to seek authority from the appropriate Health Department to prescribe a drug of dependence to a drug dependent person. This authority is required whether or not the prescription is written on the PBS.

In addition, Health Departments in some states[7] require medical practitioners to provide consultant support with an accompanying application for authorisation in respect of the proposed treatment of drug dependent persons with S8 drugs.

The following table summarises the legislative regime that applies in each state and territory when treating **non-drug dependent patients** with S8 drugs.

In all states and territories, it is a mandatory requirement for medical practitioners to seek authority from the appropriate Health Department to prescribe a drug of dependence to a drug dependent person.

Table 1. The legislative requirements when treating non-drug dependent patients with S8 drugs

STATE/ TERRITORY	LEGISLATIVE REQUIREMENT
Australian Capital Territory	Approval from Chief Health Officer (CHO) is required to prescribe a controlled medicine for more than 2 months; or if the patient has been prescribed a controlled medicine within the previous 2 months.[8] Where more than one doctor at a medical clinic is involved in the management of a patient, each doctor may prescribe under a CHO approval in place for another doctor at the clinic, provided the prescribing is consistent with and does not exceed any limits or condition of the approval.
New South Wales	Authority from Department of Health is required if patient to receive continued treatment with specified[9] drugs of addiction for more than 2 months.
Northern Territory	Notification is only required to prescribe non-restricted S8 substances (including codeine, morphine and oxycodone) for a period exceeding 8 weeks[10]; a high initial dose; a high daily dose; a high combination dose of different S8s; replacement of lost or stolen prescriptions; for "early" prescriptions; for a patient who has another S8 prescriber; for a patient who wants to transfer from another S8 prescriber; for any patient previously notified, a renewal notification must be made after 12 months if there has been a significant change to the S8 medication or a change to the person's circumstances. Authorisation is also required to prescribe restricted S8 substances (dexamphetamine, methylphenidate).
Queensland	Notification is required to the Drugs of Dependence Unit that the medical practitioner is prescribing or intending to prescribe S8s for longer than 8 weeks. Approval needs to be sought prior to treating with any "specified condition drug".
South Australia	Authority from the Minister is required before prescribing or supplying drugs of dependence for a patient's regular use during a period exceeding 2 months. Treatment provided by other prescribers must be considered when calculating the 2 month period.[11]
Tasmania	Authority is required to prescribe opioids for more than 2 months. Relevant specialist reports endorsing opioid treatment and dose should be sent with application. Concurrent prescribing of alprazolam with an opioid requires authority after 1 month's prescribing.
Victoria	A permit is required to prescribe a person with any S8 drug for a continuous period greater than 8 weeks.[12] Only one valid permit is needed for treatment of a person by more than one medical practitioner in a multi-practitioner clinic.
Western Australia	Prior written authorisation from the CEO of Health is required by medical practitioners wishing to prescribe a S8 medicine for a patient for a period longer than 60 days in any 12 month period.[13]

Summary Points

- Ensure compliance with the state and territory regulatory regimes for the prescription of drugs of dependence. It is mandatory to obtain an authority or permit from the relevant Health Department to prescribe a drug of dependence to a drug dependent person.
- Ensure there is evidence-based support before prescribing opioids and benzodiazepines to patients, particularly those suffering from chronic non-cancer pain.
- Strictly monitor prescribing rates.
- Be alert to tactics used by drug dependent persons to access drugs.
- Utilise the Prescription Shopping Information Service (medicareaustralia.gov.au/provider/pbs/prescription-shopping/index.jsp).

For a full list of references visit mdanational.com.au/misuseofopioiddrugs.

CaseBook

The Mandatory Requirement to Disclose Under the National Law

MDA National Medico-legal Adviser, Dr Julian Walter outlines several legislative disclosure requirements that are easily overlooked.

Case history

A medical practitioner was charged with high range drink driving after being breathalysed on her way home from a party. Does she have a duty to report the charge to the Medical Board?

Medico-legal issues

In 2010, following the introduction of the *Health Practitioner Regulation National Law Act 2009* (the National Law), AHPRA and the National Registration and Accreditation Scheme were born. Tucked away in a quiet corner of the National Law are several serious mandatory disclosure requirements for doctors that are easily overlooked.

a) Contact details

Section 131 *requires* that a practitioner provide written notice to the Board within 30 days of:

(1) A change in principal place of practice.
(2) A change in the address used for correspondence.
(3) A change in a doctor's name.

Failure to notify may result in action by AHPRA against the doctor.

b) Notification of "certain events"

Section 130 *requires* health practitioners, once aware of certain events, to provide written notice of these events to the Medical Board within seven days. If a practitioner fails to provide notice, they can be subject to health/disciplinary/performance review and/or action by the Board.

The "certain events" listed below are diverse and apply to all registered health practitioners (medical students are subject to the first three):

(1) Being charged with an offence punishable by 12 months imprisonment or more.
(2) Being convicted of an offence punishable by imprisonment.
(3) Health practitioner (or medical student) registration cancellation, restriction or conditions in another country.
(4) Failing to have appropriate professional indemnity insurance arrangements in place.
(5) Restriction or withdrawal of practice rights at a hospital or another facility at which health services are provided due to conduct/performance/health issues.
(6) Restriction or withdrawal of Medicare billing privileges due to conduct/performance/health issues.
(7) Authority to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine(s) is cancelled or restricted.
(8) A complaint made about the doctor to an entity under the;
    a. *Medicare Australia Act* 1973 (e.g. billing privileges)
    b. *Health Insurance Act* 1973
    c. *National Health Act* 1953 (e.g. prescribing rights)
    d. *Migration Act* 1958
    e. any other Commonwealth/State/Territory entity regulating health practitioners and their services.

c) Re-registration questions

At the annual medical re-registration date (30 September), AHPRA captures similar information in a "mandatory disclosure" questionnaire, including such matters as a doctor's:

- recency of practice
- Continuing Professional Development (CPD)
- indemnity insurance arrangements
- health impairment
- criminal history
- restriction to right of practice due to conduct/performance/health
- withdrawal of billing privileges
- withdrawal of prescribing rights
- complaints not disclosed to AHPRA that have been made to a registration authority or an entity having functions related to professional services provided by doctors, or the registration of doctors (e.g. the AMA, Colleges). Note: this will generally not require the disclosure of a medical negligence claim.

Summary Points

- Many of these notification requirements are complex and it can be difficult to know whether an individual matter must be reported.
- Given the potentially serious ramifications for failing to report, Members can contact our 24 hour Medico-legal Advisory Service on 1800 011 255 to seek further advice if they consider that they may be required to report an event.

What's On?

June 2013

11	MDA National's Medico-legal Minefield Forum **Crawley, WA**
12	MDA National's Medico-legal Minefield Forum **Mandurah, WA**
13	MDA National's Medico-legal Minefield Forum **Bunbury, WA**
14	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Intermediate Level **Melbourne, VIC**
15	MDA National's Medico-legal Minefield Forum **Crawley, WA**
15-16	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Advanced Level **Melbourne, VIC**
28	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Intermediate Level **Adelaide, SA**
29	MDA National's Practical Solutions to Patient Boundaries **Brisbane, QLD**
29-30	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Advanced Level **Adelaide, SA**
30	**Don't forget** to renew your MDA National Membership and Policy for 2013 or contact our Member Services team on **1800 011 255** if your situation has changed

July 2013

20	Australian and New Zealand College of Anaesthetists (ANZCA) and Australian Society of Anaesthetists (ASA) WA Winter Scientific Meeting **Crawley, WA**
26	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Intermediate Level **Launceston, TAS**
27-28	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Advanced Level **Launceston, TAS**

August 2013

4	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Intermediate Level **Gold Coast, QLD**
23	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Intermediate Level **Perth,WA**
24-25	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Advanced Level **Perth, WA**
25	MDA National's Perth City to Surf team competes. **Perth WA**

September 2013

7-8	The Royal Australian College of General Practitioners (RACGP) Clinical Emergency and Risk Management Program (CEMP), Advanced Level **Brisbane, QLD**
11-12	General Practice Education and Training (GPET) Convention **Perth, WA**
12	Medical Indemnity Industry Association of Australia (MIIAA) Annual Forum: Evolution in the Medico-Legal Landscape **Sydney, NSW**
25-28	The Australian Association of Practice Managers Ltd (AAPM) and Quality Innovation Performance (QIP) International Health Care Conference **Sydney, NSW**
26-29	Australian Society of Anaesthetists (ASA) National Scientific Congress **Canberra, ACT**

Find out more

To find out more or to register for any of the MDA National events:
visit **mdanational.com.au**
email **events@mdanational.com.au**
or contact 1800 011 255.

MDA National
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You can also email us at defenceupdate@mdanational.com.au with the word "subscribe" in the subject line along with your name and Member number in the body of the email.

Have you moved? Have your practice details changed?

If so, please take a moment to notify us of your new information. To update your details, please call Member Services on 1800 011 255 or log on to the Member Online Services section of our website **mdanational.com.au**.

It is important that you notify us of your updated information to ensure you maintain continuous cover and to make sure that we can continue to contact you with important information about your medical indemnity.

Freecall: 1800 011 255
Member Services Fax: 1300 011 244
Email: peaceofmind@mdanational.com.au
Web: mdanational.com.au

YouTube

Adelaide
Unit 7
161 Ward Street
North Adelaide SA 5006
Ph: (08) 7129 4500
Fax: (08) 7129 4520

Brisbane
Level 8
87 Wickham Terrace
Spring Hill QLD 4000
Ph: (07) 3120 1800
Fax: (07) 3839 7822

Hobart
GPO Box 828
Hobart TAS 7001
Ph: 1800 011 255
Fax: 1300 011 244

Melbourne
Level 3
100 Dorcas Street
Southbank VIC 3006
Ph: (03) 9915 1700
Fax: (03) 9690 6272

Perth
Level 3
88 Colin Street
West Perth WA 6005
Ph: (08) 6461 3400
Fax: (08) 9415 1492

Sydney
Level 5
AMA House,
69 Christie Street
St Leonards NSW 2065
Ph: (02) 9023 3300
Fax: (02) 9460 8344